MINUTES
of the
FOURTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

September 8-10, 2004
New Mexico State University Corbett Center
Las Cruces, New Mexico

PRESENT
Sen. Dede Feldman, Chair
Rep. J. Paul Taylor, Vice Chair
Sen. Rod Adair
Sen. Steve Komadina (9/8)
Rep. Terry T. Marquardt (9/8)
Sen. Mary Kay Papen
Rep. Jim Trujillo

ABSENT
Rep. Rory J. Ogle

Advisory Members
Rep. Gail C. Beam (9/9, 9/10)
Sen. Sue Wilson Beffort (9/8, 9/9)
Rep. Ray Begaye (9/9)
Rep. William "Ed" Boykin
Rep. John A. Heaton
Sen. Linda M. Lopez (9/8, 9/9)
Rep. Antonio Lujan
Rep. Edward C. Sandoval
Rep. Gloria C. Vaughn
Rep. Ron Godbey
Sen. Timothy Z. Jennings
Rep. James Roger Madalena
Rep. Rick Miera
Rep. Al Park
Rep. Danice Picraux
Sen. Bernadette M. Sanchez
Sen. Leonard Tsosie

(Attendance dates are noted for those not present for the entire meeting.)

Staff
Phil Lynch
Raul Burciaga
Ramona Schmidt
Karen Wells

Guests
The guest list is in the meeting file.

Wednesday, September 8
The meeting was called to order by the chair at 9:10 a.m. Members of the committee and committee staff introduced themselves. Senator Feldman reviewed the agenda for the September 8-10 meeting.

Dr. Michael Martin, president of New Mexico State University (NMSU), welcomed all. He spoke to the history of NMSU and its beginning as a land grant university. He stated that $93 million in capital improvements have begun on campus. Strategic targets are being refined and will be reported to the general public to ensure good stewardship.

Anthony Levatino, M.D., one of several Las Cruces obstetricians testifying, addressed the increasing costs of medical business expenses but noted that fees have been frozen. The increasing cost of medical malpractice insurance premiums continues and is expected to increase 20 percent annually over the next two years.

Jan Siebersma, M.D., spoke to the low Medicaid and Medicare reimbursement rates and the effect on treating patients and remaining in business. Reimbursement rates for patients with insurance are also being cut back. Medical malpractice insurance costs are between $60,000 to $70,000 a year for a physician with no malpractice judgments; if there are recent judgments, the cost increases by 30 percent.

Marco Duarte, M.D., stated that a year ago the New Mexico Medical Society spoke with the Department of Health (DOH) to address the impact on the obstetrics practices in the southern part of New Mexico. He noted that it was through philanthropic efforts that funding was attained to protect the obstetrics program at Memorial Hospital with the onset of the competing for-profit hospital. Dr. Duarte spoke to the epidemic of "white coat" flight in the state and noted that recent graduates of the medical schools in New Mexico and Arizona are not remaining in the state.

Randy Marshall, director of the New Mexico Medical Society, addressed recent legislation to assist the medical profession within the state. Mr. Marshall spoke of the medical malpractice crisis in the state and reviewed the implementation and structure of the federal Medical Malpractice Act of 1976. He reviewed the New Mexico Medical Review Commission annual report's year-end 2003 statistical and historical data.

John Anderson, legal counsel for the New Mexico Medical Society, stated that the society is unable to develop a way to remedy the issue for reimbursement other than recommending that the DOH add to its budget $600,000 to be matched federally to provide reimbursement for obstetrics in the state.

Jeff Haysley, regional claims manager for the American Physician Insurance Division, stated that rate-making expenses vary dramatically from specialty to specialty. Mr. Haysley stated that generally there are between 225 and 300 new medical malpractice claims submitted annually in the state at an average of $120,000 to $130,000 each. A case taken to trial, win or lose, will run between $75,000 and $125,000 for expenses notwithstanding judgment costs.

Issues raised included:

- the main reasons for rate increases in the state;
- injury cases versus noninjury cases;
- fee limits on attorney fees;
- clarification as to the $600,000 limit being a non-medical limit on damages; and
- the percentage of cases that proceed to trial.

Linda Siegle, lobbyist for Nurse Midwives, introduced Rhonda Cox, CNM, First Step Clinic, who spoke about the practice and reimbursement of nurse midwives. The cut in Medicaid reimbursement greatly impacts nurse midwives who serve in rural areas. Certified nurse midwive's statistics that affect practice were shared with the committee. Cathryn Autrey, CNM, spoke about her role in private practice and reimbursement issues, including contract reimbursement, malpractice insurance premium increases and patient pay.

Mary Lou Singleton, a licensed midwife, noted that licensed midwives are regulated through the DOH but are in the independent home setting as opposed to nurse midwives who serve mostly in the hospital setting. New Mexico Midwives Association facts and policy issues were shared. The impact of SALUD! on licensed midwives was discussed. It was suggested that the Medical Malpractice Act be amended to cover licensed and nurse midwives as providers.

Marcy Andrew, northern New Mexico Midwifery Center, spoke to how the center can be used as a model and reviewed accreditation, demographic data and statistics. Costs related to Cesarean section births and infant mortality rates were discussed. Malpractice claims against the center have never occurred but the center is at risk of being put out of business due to the increasing costs of malpractice insurance.

Beth Enson, dean of students at the National College of Midwifery, addressed the immediate crisis of midwifery facing the state.

Issues raised included:

- the increasing number of individuals who drop their private insurance if they are also eligible for Medicaid reimbursement under the low-income birth program, which results in lower reimbursement for nurse midwives;
- whether the Patient Protection Act guarantees that MCOs must contract with licensed midwives;
- the vast majority of licensed nurse midwives cannot afford to pay for malpractice insurance, which results in limitation of practice settings;
- the education and certification requirements of midwives;
- the use of binding arbitration and/or mediation as an option for malpractice claims; and
- looking at placing nurse midwives under a state pool if they would serve the general public.

Bill Webber, director, New Mexico Trial Lawyers Association, spoke as a citizen of Las Cruces and shared his personal perspective. In the past several years, there has been a paradigm shift requiring all parties to work together. He stated the health care crisis is a subset of the insurance crisis, not a malpractice crisis. Mr. Webber suggested looking at systemic solutions for systemic problems.

Issues raised included the percentage of settlement costs that actually goes to the patient.

Dr. Duarte of the First Step Clinic spoke to efforts to protect health care in the southern part of the state drawing on individuals from conflicting areas who have worked together to craft solutions to ensure continued coverage of care.

John Hummer, CEO, Mountain View Hospital, addressed the need for critical relief for obstetricians in New Mexico. He asked the committee to influence the state agencies who set the Medicaid budget in addressing fees for obstetricians. He noted current requirements by HSD related to switching insurance coverage, and its effect on the number of individuals who are able to drive across the New Mexico border to El Paso for Medicaid coverage.

Paul Herzog, CEO, Memorial Medical Center, thanked Representative Taylor and the other members of the committee for their dedication and hard work with the health care issues facing the state. Mr. Herzog spoke to reduction in the federal match for Medicaid and the decrease in the incomes of those individuals who are on Medicaid. The reductions in provider payments and for graduate medical education and the 10 percent limit in Medicaid cost report settlements are especially burdensome to Memorial Hospital. Matt Onstott, HSD, stated staff is working with attorneys to address the 10 percent Medicaid cost reimbursement issue. The rate reduction may impact hospitals that serve a larger Medicaid population more adversely.

Joie Glenn, executive director of Home and Hospice Care, gave an overview of the costs of dying and hospice in New Mexico. She spoke to the palliative care issues offered through hospice and custodial care, which can be received through personal care options and waivers.

Nancy Wertz, chair, Alamogordo Home Care and Hospice, said that hospice provides nursing services, monitoring of systems and pain, home health aids and social workers for financial issues and counseling. Hospice reimbursement rates were reviewed. Discussion ensued as to definitional issue importance in allowing hospice patients a choice to care. Reimbursement for PCO is $13.50 for the first 100 hours and $11.50 after 100 hours. Representative Taylor spoke to the need for hospice as well as palliative and custodial care to ensure a continuum of care. An individual must have a prognosis of six months or less to qualify for hospice care.

Issues raised included:

- the high cost of personal care options;
- the effect of new regulation in terms of lowering cost; and
- cost shifting to end-of-life quality of care.

Walter Forman, M.D., professor of internal medicine, School of Medicine, addressed pain management issues. In a survey, the number one issue is pain. The issue of chronic pain is a simple concept but there are several aspects that make physicians afraid to treat it. Four issues commented on were: 1) awareness that pain is not necessarily a part of living; 2) there is very little education on how to treat pain and so physicians want to increase education on pain management; 3) for those individuals who prescribe pain medication, adding a licensure requirement for pain management education; and 4) to present to the public some concepts on what they should say to their providers. There are legal issues faced by physicians prescribing pain medication.

David Bennahum, M.D., spoke to ethical considerations in end-of-life medicine and the demographics of individuals within the state in providing adequate care and the competition for funds. Dr. Bennahum stated the following needs need to be met for individuals:

- clarity that even individuals with dementia are autonomous;
- informed consent as to what works and what does not work;
- respect of personal dignity;
- freedom from abuse and neglect;
- freedom from pain; and
- respect for privacy.

Dr. Bennahum noted the failure to cover undocumented workers and the lack of universal health care in the United States and the amount of money spent compared to other countries.

Mollie Wallsteadt, long-term care ombudsman, Aging and Long-Term Services Department, spoke to the need for hospice. Issues include providing a choice and giving residents the time they need in making decisions.

Robert Cantrell, M.D., addressed contemporary treatment for the elderly. Biological, psychological and sociological aspects were discussed. Dr. Cantrell stated, "you cannot expect nursing home patients to be stimulated mentally by staff. If you have dementia and are around your family, you will be taken care of; if you have dementia and are taken care of by staff, you are a commodity." Dr. Cantrell noted that the state needs to create an environment that supports individuals being taken care of by family and friends. He stated that many providers who treat geriatric patients are no longer accepting Medicare patients. Dr. Cantrell noted that the state is reaching the top of its asymptotic curve on health care spending.

Issues faced include:

- the need for advanced directives;
- the dilemma of taking care of families while living thousands of miles away;
- prognostication and understanding psychologically the importance of giving correct diagnosis toward end of life;
- the capacity to make health decisions and locus of control;

- decisions that assist individuals in making the end-of-life situations; and
- life expectancy, improved technology and quality of life.

Public comment was given by Becky Becker.

Tracey Cox, executive director, Community Action Agency of Southern New Mexico, stated that it had been refused funding for the past year. She spoke to the need to cut care in some areas. The agency is projecting an $80,000 deficit next year and is doing everything to protect the elderly and children. The agency is looking at building affordable housing in Anthony and Las Cruces, and is also looking at some single-family unit construction. Ms. Cox stated that business ventures are needed that support the mission of ending poverty in southern New Mexico.

Ms. Cox noted some issues in connection with the proposed casino in Anthony:
- there needs to be a safety net in place and support for gamblers;
- money in the community is moved around rather than brought into the community;
- how many full-time jobs and jobs with benefits would it produce; and
- the financial literacy rate in southern Dona Ana County.

Allen Crane, Las Cruces Lions Club member, addressed the committee and stated that New Mexico is at the bottom of all states in terms of reading. A video of the Lions Crane Reading Program was shown that addresses improving reading in elementary schools. One hundred twenty out of 147 children at Valley View Elementary School who had eye exams were given eyeglasses. Mr. Crane noted many children do not receive adequate eye exams because most parents think the annual school eye exam is appropriate. Farsightedness and astigmatism are much more prevalent in elementary school children than had been recognized previously. Jamie Jones, principal at Valley View Elementary School, spoke to the dramatic improvement after evaluating and treating children with poor vision. Other states have legislated the same requirement for eye examination for children entering public schools, just as immunizations are currently required. Programs are being rolled out across the state. Senator Feldman suggested speaking with the DOH to provide eye exams throughout schools. It was stated that the biggest concern is to ensure that children get eyeglasses and not just complete the exam.

The meeting recessed at 6:03 p.m.

Thursday, September 9

The committee reconvened at 9:10 a.m.

Michael Trujillo, M.D., MPH, University of New Mexico School of Medicine, reviewed the demographics of Native American/Alaskan Indians, with New Mexico ranking fifth in terms of population and Albuquerque ranking fifth for urban American Indians. The relationship between tribes and the federal government or the state is government-to-government and is critically important in understanding policy and funding. When one speaks to a citizenship of American

Indians, one must remember they are citizens of three entities, the United States, the state and the tribe. Disparities exist not only in terms of health care but also are social, economic and cultural. Dr. Trujillo stated that a recent report speaks to Native Americans living in third world conditions. He noted the scene is changing in Indian Health Service as more money is going directly to the tribes to manage their health care. Dr. Trujillo recommended that committee members read the United States Commission on Civil Rights Office of the General Counsel report titled "Broken Promises: Evaluating the Native American Health Care System". Universities, foundations, managed care programs and research entities all work together to address disparities in Indian health services.

Dr. Trujillo noted a number of reimbursement issues that could help Indian health services, managed care organizations and hospital systems and that training of other entities and providers is necessary in dealing with Indian health services. There are relationships that can be extended through the governor's office, the legislature and state agencies that could assist with appropriate and adequate funding for better health care for individuals within the state. Indian health care is not solely a Republican or Democratic concern but is an issue for all to address.

Questions and issues raised included:

- getting proper health care in terms of collaboration;
- working through UNM to offer expanded services and community development, early detection and prevention;
- identifying issues through the Social Services Division of the DOH and the schools;
- how the general health of the American Indian is improving but life expectancy is five to seven years less than the general population;
- the effect of gaming on improvements in health depends upon location; and
- the health care funding streams coming into the state are difficult to track because of different methods of accounting.

When asked if it is better to treat Native Americans separately or better to mainstream them into the system serving the general population, Dr. Trujillo noted that this is an extremely complex issue and to begin changing the relationship may begin a slide down a slippery slope of termination. He cautioned the state has to be extremely careful that it does not get bogged down in the process of termination; relationship of sovereign nations and tribal leadership is needed in the process.

Lisa Cacari Stone, Ph.D. and Dan Reyna, M.P.A., director of border health, addressed health disparities in New Mexico. Ms. Stone used the definition of "health disparity" from Healthy People 2010, USDHHS, which is: "… differences that occur by gender, race, ethnicity, education or income, disability, living in rural localities or sexual orientation". She noted there is some progress in new and emerging problems.

Ms. Stone reviewed these issues.

- There is evidence of racial and ethnic disparities in health care in the areas of:

    - cardiovascular care;
    - cancer;
    - cerebrovascular disease;
    - renal transplantation;
    - HIV/AIDS;
    - asthma;
    - diabetes;
        - analgesia;
    - rehabilitative services;
    - maternal and child health;
    - children's health services;
    - mental health services; and
    - clinical and hospital-based services.
- Hispanic/Latino statistics in New Mexico include:
    - 42 percent of population is Hispanic;
    - over 90 percent of Hispanics are native born;
    - 1990-2000: 24 percent growth rate for Hispanics as compared to 16 percent growth for total population; and
    - 1997-1999: 34 percent of Hispanics living in poverty as compared to 16 percent whites.
- Latino health statistics show that:
    - in New Mexico, Hispanics had the poorest perception of their health, the highest rates of teen births, drug-related death, firearm injury death, chlamydia and binge drinking.
- Barriers to accessing health care include:
    - lack of qualified health professionals;
    - language barriers;
    - lack of cultural proficiencies by providers and health systems; and
    - prevention and primary care.

Mr. Reyna addressed the following border health issues and statistics:

- "If the United States border were its own state, it would rank last in access to health care; second in death rates due to hepatitis; third in deaths related to diabetes; last in per capita income; and first in the percentage of the uninsured." Source: Imagen, Special Health Issue, 2003;
- six New Mexico counties are considered border counties: Dona Ana, Grant, Hidalgo, Luna, Otero and Sierra;
- population:
    - Hispanic population in United States is 12.5 percent, in New Mexico, 43 percent, in New Mexico border region, 52 percent;
    - youth population in United States is 21 percent, in New Mexico, 31 percent, in New Mexico border region, 31 percent; and

    - estimated population growth from 2000 to 2010 in New Mexico is 15.9 percent, in New Mexico border region, 20.5 percent;
- New Mexico health manpower:
    - physicians: border rate is 60 percent lower than the non-border counties;
    - nurses: border rate is 32 percent lower than the non-border counties; and
    - dentists: border rate is 55 percent lower than the non-border counties;
- border health conditions:
    - teen pregnancy in New Mexico;
    - STDs; and
    - binge drinking;
- New Mexico disparities overview:
    - Native Americans generally experience the worst rates; and
    - white non-Hispanics experience the best rates.

Ms. Stone stated that people ask, "Health disparities – what can we do?", and then reviewed catalysts for change:

- step 1: identify health disparities as a problem;
- step 2: legitimize disparities agenda into state infrastructure;
- step 3: prioritize;
- step 4: develop multi-level strategies and interventions;
- step 5: dedicate resources;
- step 6: implement; and
- step 7: evaluate and monitor progress.

She then shared a handout from the Institute of Medicine in 2002 entitled, "Unequal Treatment Confronting Racial and Ethnic Disparities in Health Care" with a summary of recommendations.

Questions and issues raised included:

- whether recommendations made under the "Unequal Treatment" handout could be turned into performance measurement categories;
- the need for disease management and health improvements in the school systems, including review of the use of vending machines, after-school programs and improved physical education;
- all sectors needing to work together with clear priorities, commitment and sustainability to address the level of poverty, including the administration, judicial system, school system and the legislature; and
- that issues such as diabetes do not show up as disparities because they affect all populations.

Vicky Johnson, M.A., manager and clinical supervisor, First Born Program, Grant County Regional Medical Center; Susie Trujillo, Grant County Community Health Council; and Ivan A. de la Rosa, School of Social Work, NMSU, presented information on the First Born Program in the Gila Regional Medical Center, including:

- it is an evidence-based program for creating resilient families;

- it was designated as one of the nation's 10 most exemplary and innovative prevention programs in 2002 ;
- it addresses multiple goals such as immunization rates, child abuse and neglect, substance abuse, school dropout rates, domestic violence, late or no prenatal care, teen parenting, nutrition, obesity, diabetes and teen pregnancies;
- home visitation reaches many populations;
- it meets community priorities, has strong medical community support, has universal access, has rigorous staffing requirements, community involvement and collaboration, clear research-based program theory, rigorous documentation protocols, strict confidentiality protocols and staff supervision;
- the First Born Program Tool Kit includes three core curricula, training protocols, program documentation protocols and evaluation protocols;
- it will lead to an increase in healthy, resilient infants and overall savings in health care costs; and
- management and funding sources were described.

Issues raised included:

- it was proposed to use the First Born Program as a state model;
- it was noted that one of the ways to best address risky behavior is through home visits; however, the evidence of success is a long way off and it is costly;
- it was suggested to present before the Legislative Finance Committee a comprehensive approach on diverting children from a life of crime;
- it would be useful to have standardization for funding criteria from state agencies and have minimum qualifications published for future home visiting programs, including best practices; and
- evaluating the program and seeing what is offered in other communities.

Maria Navarro Pino, the weaving instructor from the Community Action Agency of Southern New Mexico, brought samples of weaving and spoke to the fellowship and camaraderie of the women.

Mr. Reyna and Alice Salcido, MPH, MCH, Office of Border Health, DOH, addressed the Community Health Worker Training project, which involves:

- lay community members;
- identification of emerging needs;
- the purpose, action and key training recommendations as required by Senate Joint Memorial 76;
- the Office of Border Health actions in response to findings and recommendations, including:
    - developing a computer literacy training curriculum;
    - conducting a pilot computer literacy training course;
    - completing evaluation of training course by use of a Master of Public Health thesis; and

    - presenting pilot course findings to the Border Health Council Advisory Committee;
- an evaluation study was done as to relevance, implications and methodology regarding:
    - whether the project is reaching the targeted group; and
    - its effect on computer literacy; and
- the findings and recommendations were presented to Border Health Council.

Questions were raised as to center locations, start-up costs and other capacity and sources for funding and the right faculty for training. It was noted that this is one of the most successful programs along the border. The Office of Border Health staff was commended.

Mr. Reyna gave an update on the federal issues impacting border states, including:

- the implementation of Section 1011 of Medicare law affecting reimbursement to hospitals, physicians and ambulance services for providing emergency health care to undocumented immigrants;
- two bills that are before the United States Senate to halt the current practice of allowing prescription drug re-importation across the borders:
    - the impact along the United States-Mexico border was discussed;
    - the members of the Border Legislative Conference directed staff to develop a resolution for the review and approval of the chair and vice chair, expressing the Border Legislative Conference's opposition to legislation in United States Congress aimed at reducing the amount of prescription medication that can be purchased in Mexico and crossed into the United States; and
    - Office of Border Health actions were reviewed.

Issues and questions included:

- the impact on the poor and elderly who do not qualify for drug company programs offered;
- concern over the proposed information collection instrument for documenting citizenship;
- border health staff had not seen events of harmful occurrences or risks with prescription medicine brought across from Mexico; and
- discussion as to advertisement and publication of information related to purchase of prescription drugs in Mexico.

Public comment was offered by Dr. Bill Wiese, M.D., as to disparities in health care services.

Harriet Brandstetter, CEO, La Clinica de Familia, a 501(c)(3) organization serving Dona Ana County, spoke of moving the First Step Clinic from Memorial Hospital to La Clinica de Familia.

Peggy Swoveland, interim director and member of the board of directors of the First Step Center, addressed the importance of pursuing the integration with La Clinica de Familia. Ms. Swoveland addressed some reasons for the integration of the two, including:

- without the subsidy from Memorial Hospital, the center was not able to meet its financial needs;
- because La Clinica de Familia is a federally qualified health center, it receives higher Medicaid reimbursements, which also improves funding for the First Step Center; and
- the move ensures coordination of care rather than competition.

Dr. Frank Crespin, M.D., described the safety net in Dona Ana County. The two hospitals there provide a large volume of emergency services as well as inpatient services, some of whose costs are offset by the County Indigent Fund, and two federally qualified services: Ben Archer Health Center and La Clinica de Familia. Dr. Crespin stated that even with all of the resources provided, it still cannot cover all of the needs for health care service. He said the hope is to weave the safety net together by joining forces with the First Step Center and to eliminate duplication of services and close existing gaps. The county applied for a federal grant in June and will hear of its status by the end of September.

Issues included:

- La Clinica de Familia and the First Step Center staff were encouraged to apply for the breast and cervical cancer dollar match through Medicaid; and
- the process for capital outlay funds must be handled through public agencies rather than given directly to not-for-profit organizations in order to not violate the anti-donation clause.

Senator Feldman reminded committee members that they have the opportunity to comment on the managed care physical health RFP concept paper and asked if the committee would like to respond as a group. Mr. Burciaga reviewed the general language of SB 338, which speaks directly to program changes with approximately 24 specific changes, and HB 412, which has pilot project analysis. Committee members agreed that a letter should be submitted addressing the following:

- health care disparities in the SALUD! contract;
- a reminder of the law that requires the establishment of a PDL;
- mention of the promotoras;
- a separate letter to request being kept abreast of the behavioral health RFP timelines (Mr. Burciaga stated he will keep the committee informed of RFP timelines);
- requesting regular reports from the MCOs regarding costs. Mr. Burciaga noted that the Medicaid Reform Task Force attempted to require that information but was informed the MCOs were not willing to share proprietary information that was gathered before contract negotiations; and
- recommend providing financial incentives for practices that reduce barriers and encourage practice-based medicine.

Mr. Burciaga said he will attempt to locate and report to the committee information regarding the behavioral health RFP by the end of the meeting on Friday.

The meeting recessed at 4:17 p.m.

Friday, September 10
Representative J. Paul Taylor reconvened the meeting at 9:20 a.m.

Jeffrey E. Brandon, Ph.D., Dean, College of Health and Social Services (CHSS) New Mexico State University, gave an overview of the college's programs, which included:

- the mission of the CHSS;
- the CHSS vision;
- the academic units and degrees within the CHSS; Department of Health Science; Department of Nursing; and School of Social Work;
- CHSS total enrollments;
- increase enrollments in new undergraduate, graduate and transfer students;
- increase the number of articulation agreements with two-year colleges;
- research and external funding;
- increase multidisciplinary collaboration to expand research; the singular focus area for research within the CHSS through all disciplines is the focus on health disparities;
- expansion of distance education;
- CHSS is seeking to expand health work force development initiatives and integration of service learning and civic responsibility;
- increase resources within CHSS with the university-wide goal of a comprehensive campaign fundraising;
- new resources are inadequate in light of growth in the nursing situation and in social work; and
- the alignment of CHSS programs with the land-grant tradition.

The committee members and staff were introduced.

Stephen D. Arnold, academic department head of health science, addressed the following:

- degrees offered;
- the accreditation process in the BCH undergraduate program, the MPH graduate program, and the EOH undergraduate program;
- the field experience required for graduation;
- the current enrollment;
- the outreach centers;
- the health science external funding amounts; and
- the additional contributions to NMSU.

Mr. Emilio Hokis informed the committee about the Southern Area Health Education Center

- seven focus areas; continuing education and training programs; school-based health career awareness and preparation; bilingual leadership training; environmental health and home safety education to families and communities; regional health conferences and

workshops; partial support for the placement of health professional students and residents; the development of a core group of regional trainers;
- funding sources;
- SoAHEC and BHETC programs offered;
- health careers opportunity program funded by HRSA;
- the youth health clubs, which operate in three middle schools, offering a variety of extracurricular educational activities focusing on pursuing health careers;
- environmental health funded by the DOH and the Office of Border Health;
- diabetes prevention funded by the Paso del Norte Health Foundation;
- SoAHEC/BHETC bilingual community training;
- training topics include: cultural competencies, team building, conflict resolution, grant writing, communication skills, group facilitation for effective meetings, time management, pesticide safety and first aid-CPR certification; and
- continuing education sponsorship.

Dr. Hugo Vichis, M.D., director, Border Epidemiology and Environmental Health Center (BEEC), addressed the following:
- the mission of the BEEC to preserve and enhance the health of the state's border population and its border-impact areas;
- the purpose of the BEEC;
- the main strategy to assist and protect border populations through research, education and community health;
- the benefits being provided to NMSU serve as a link to the community and to DOH and as a lab for the students, with inter-college cooperation and internationalization of border health experience; as a contract office for the Office of Border Health; as a link with academia, with access to university resources; and as a binational-international approach to border health issues;
- BEEC functions and programs;
- partnerships in the United States and Mexico;
- current projects were reviewed and include: terrorism and emergency response, binational infectious disease surveillance, binational mosquito control and surveillance, "Health Gente" 2010 objectives, international practicum and internships, Espejo Project, Nuestros Ninos Project, Vacuname! Project and BIEN! – Border Health Information and Education Network; and
- achievements, including lead projects-activities adopted by other agencies, BIEN!, supporting promotora development, data collection and analysis and border profiles.

Martha G. Roditti, MSW, Ph.D., field coordinator for the NMSU School of Social Work, addressed:
- the School of Social Work's community focus that reflects the mission of the land grant university;
- the educational model for the undergraduate and the MSW program;
- the social work profession being unique among professions;

- the programs of the School of Social Work include BSW, MSW, the Title IV-E Project, permanency planning training; Albuquerque expansion – 11 students in January 2002 to 51 in 2004, and offer a special credential minor in substance abuse;
- social work deals with more than welfare work and child welfare — there are 111 agencies providing over 30 different types of service;
- the school of social work field program has 170 students in the field for a total of 81,730 hours a year or the equivalent of 10,216 days of service;
- social work meets human needs: children and families services, poverty, child abuse and neglect, domestic violence, reunifying children with families and youth transitioning out of foster care;
- what the school of social work does for the state of New Mexico includes evaluating domestic violence and substance abuse programs, research into child poverty and the high rate of neglect, evaluate use of FACTS program in CYFD, research into child abuse and child death, delivery curriculum on retention of social services staff, evaluating cross disciplinary partnerships for CYFD, health, substance abuse and juvenile justice and research into family networks of the elderly; and
- in the future the school would like to work in partnership with a wide range of programs, collaborate with the university on research and benefit the people of New Mexico.

Mary Hoke, Ph.D., nursing department head, reviewed the following information:

- a snapshot of the nursing shortage that remains a concern nationally;
- the mission of the NMSU Department of Nursing is to serve the people of New Mexico through nursing education, research and public service;
- accreditation is through the Commission on Collegiate Nursing Education through 2012 and is approved by the state Board of Nursing through 2010;
- the BSN program, pre-licensure four-year BSN;
- the RN to BSN program;
- the master of science in nursing;
- community service activities;
- funded research projects;
- health resources administration;
- southern New Mexico RN to BSN expansion;
- roadrunner is an alternative program for students with bachelor degrees in other fields;
- mental health improvement through nursing distance education;
- National Institute of Nursing Research; and
- future projections to expand the nursing education mission and expand nursing research and grant programs.

Dr. Hoke stated that the FY 2006 nursing education request is to continue $425,000 in direct funding for NMSU nursing, which includes continuing the annual allocation of $375,000 to sustain the RN to BSN option; and a one-time only funding of $125,000 to support the nursing doctoral program.

Questions and issues raised included:

- raising tuition for programs that are in higher demand and the impact on students who are working, which may result in hindering those who could not afford higher tuition;
- working with the three hospitals in town for funding;
- available funding sources;
- what level of nurse can prescribe medication;
- the need for nursing education funding to be given to NMSU as well as UNM;
- clarification on funding requests for nursing and how previously appropriated money had been used;
- whether there are collaborations between the social work program at New Mexico Highlands University and NMSU;
- a desire to recruit more Native Americans in the nursing and social work programs and the hiring of a Native American faculty member;
- NMSU began the Albuquerque program to ensure statewide service and placement;
- the effect of air pollution, peak time periods in El Paso-Juarez and Las Cruces, the effect on border health and what is being done by Mexico to improve the quality of air and the type of heat source;
- how border states are working with their Mexico sister states to address terrorism concerns and the needs and resources of the responders; and
- the nursing shortage, the history of shortage followed by excess and the effect of increasing education required for growing technology.

Elaine Levine, Ph.D., stated that the psychologists prescriptive authority needs have increased during the past three months. She noted the dearth of psychiatric care and threat of collapse in the mental health area because of increasing costs to care for individuals. She stated that it has taken time to implement the law after it was passed to allow for a joint agreement to be developed between psychology and the medical communities regarding procedures.

Luis Vasquez, Ph.D., chair, Counseling and Educational Psychology Department, noted that it is responding to a need in the state. Representative Sandoval said there is one more public hearing and then the board will vote. He stated this was initiated because of the lack of access to behavioral health care in the rural areas of the state. He noted that there are nurses who have prescriptive authority but there has been a struggle with individuals with Ph.D.s being able to prescribe. He cautioned that it is possible another bill will be presented during the upcoming legislative session to cancel the first bill.

Representative Taylor stated many individuals may want to speak to the Presbyterian Salud! changes but cautioned the audience that time may not allow all to voice their opinions.

David Scrase, M.D., CEO, Presbyterian Health Plan, stated that the purpose of Presbyterian Health Care is a commitment to improving the care of New Mexicans. Dr. Scrase noted that although Presbyterian has lost money on the Salud! contract, it is committed to providing care for New Mexicans. He stated that Presbyterian has initiated cost containment measures but is no

longer in a position to pay more than Medicaid prescribes under its fee-for-service schedule. The HSD has maintained oversight over Presbyterian. He noted that Presbyterian has a strong commitment to behavioral health care. Dr. Scrase stated that if there are members or providers or consumers of Presbyterian Salud! services who are in attendance today and who have specific questions, he and Presbyterian staff members here today will answer their questions personally. Representative Taylor asked Dr. Scrase to share a copy of his remarks with the committee members. (Dr. Scrase's detailed remarks are available in the archive file.)

Questions and issues raised included:

- Representative Heaton stated that he is concerned with Presbyterian being able to reduce provider payments by $40 million as noted by Dr. Scrase. There is a serious problem with a lack of providers in the state and especially in the rural area. There is concern regarding the ability of MCOs to reduce rates and its effect on diminishing the quality of health care in the state;
- an issue was raised regarding Presbyterian not contracting with physicians outside areas of the state in which they have networks;
- Matt Onstott, HSD staff, noted HSD did not want to make the cuts that it had to make but it has to find $40 million to $50 million of funds in state funds and understood that when it negotiated a flat contract with all three MCOs, it would need to make cuts with its providers. They all agreed to accept the Medicaid fee schedule;
- Representative Lujan asked for clarification on behavioral health and said he understands that 3,400 individuals were affected rather than the 1,400 noted by Dr. Scrase;
- clarification as to what makes up a behavioral health provider network, as required by Medicaid participating entities, to ensure all members have access and that a certain number of providers are required in areas;
- contracts with providers relating to exclusivity and privileges at hospitals;
- concern that if a network disappeared, individuals may no longer be able to receive treatment and rural areas might be underserved;
- a concern of the committee that elimination of a network would result in individuals being left without services;
- concern as to transition period when network changes are made;
- changes in Presbyterian prescriptive requirements and the possible effect of cutting out pharmacists in small or rural areas;
- the status of contractual arrangements between Presbyterian and Rio Grande Behavioral Health, to which Dr. Scrase responded that the contract ended July 31 and a two-month continuation of care arrangement is in place;
- a request was made to Dr. Scrase to provide a listing of providers with whom Presbyterian has contracted for behavioral health services; Dr. Scrase stated that a copy of current providers is available publicly but those with whom Presbyterian may be contracting may be part of current litigation and thus are not available for current disclosure;

- Dr. Scrase was asked how many lawsuits Presbyterian is involved in and he advised that one is the current lawsuit relating to behavioral health and one is a pharmacist against the state and Presbyterian on pharmaceutical issues;
- Mr. Onstott was asked about the 800 Medicaid beneficiaries that will be transferred from Presbyterian to the other MCOs and what the impact will be on costs;
- concern about hospitals dropping out of the Medicaid program and how it affects access by Medicaid clients;
- the lack of a long-range plan on the part of HSD-MAD, i.e., a concept paper about what the Medicaid cuts in reimbursement and services will do to the Medicaid beneficiaries as well as the infrastructure, e.g., OB-GYN services;
- HSD-MAD efforts to minimize the effect of Medicaid cost containment initiatives;
- Senator Feldman provided the committee with copies of a July 23, 2004 letter from Presbyterian to the behavioral health providers in the southern part of the state; and
- Representative Taylor discussed his concerns with the numerous reductions in financing of health and human service issues and the impact that it has on the southern part of the state where the demands are significant and growing.

Noel Clark, CEO, Carslbad Mental Health Association; Vincent Ortega, CEO, Southern New Mexico Human Development in Anthony, New Mexico; and Sam Vigil, CEO, Valencia Counseling Services, Los Lunas-Belen, discussed their concerns with the changes in behavioral health services structure under Medicaid managed care. Mr. Clark expressed his concern with the deterioration of behavioral health services. Does Presbyterian's provider network provide the community norms expected and required? Second, does Presbyterian include the types of services needed? If the answer to these questions is no, then who is responsible for the oversight of Medicaid services?

Mr. Ortega discussed the challenges that have come about as a result of managed care, that some challenges have been solved and that many remain. Cost containment initiatives were cited as a reason for the decrease in services, including critical ones no longer being provided in an emergency setting. Mr. Ortega advised that the current Presbyterian network is limited, fragmented and insufficient for the needs of the consumer community. Mr. Ortega recommended that an independent investigation of Presbyterian contract activities be conducted, as well as appropriate oversight of Presbyterian's managed care program activities.

Mr. Vigil thanked the committee for the opportunity to be heard and provided a brief overview of Valencia Counseling Services. He discussed some of the problems encountered by mental health patients under the new Presbyterian arrangements.

Public comment on behavioral health issues included:
- concerns about the change in case management and mental health providers;
- changes or limitations in services provided;
- how referrals to other providers resulted in limited or no access to required services;

- persons who are unable to speak for themselves or provide for themselves without significant assistance;
- inconvenience and impact on persons with special needs who are required to change providers and thus have different transportation needs;
- how the status quo is important to persons with mental and behavioral health needs because change is quite disconcerting;
- that the case manager advised the committee that many services are not available despite Presbyterian's assurances to case managers and consumers that they are;
- that the transition to new services or providers could be traumatic for mental health clients;
- many of these patients now easily fall out of the system and because of their unique conditions or circumstances, they lose eligibility and end up without needed services;
- transitions have been very difficult with mental health patients, i.e., managed care in 1997, transition from behavioral health organizations to managed care organizations, Presbyterian assumption of behavioral health services and the anticipated transition to a behavioral health collaborative in 2005;
- mental health patients need continuity, and the transition to a new system or to new providers interrupts the continuity that patients have come to expect and depend;
- capitation results in under-service to the Medicaid population; and
- results of a two- or three-year-old study relating to administrative expenses of behavioral health organizations were discussed.

Representative Taylor and Senator Feldman expressed their hope that Presbyterian and Rio Grande Behavioral Health could come to some agreement to resolve the situation.

Paul Ritzma, counsel for HSD, advised that HSD takes its oversight responsibility very seriously and will investigate any issues relating to disruption or discontinuity in services.

Madeline Gillette, chair, Mental Health Task Force, and Ron Gurley, Dona Ana Mental Health Collaborative, discussed the need for a regional psychiatric hospital. Mr. Gurley thanked the committee for its support over the years and for its commitment to meeting the needs of mental and behavioral health patients. The number of psychiatric beds has dropped considerably; there are only 12 locked, secure beds in southern New Mexico (at Memorial Medical Center), while there are 108 beds at Las Vegas Medical Center and 85 beds at UNM Hospital. The committee was given a handout that included draft legislation for a $2 million appropriation to plan, design and implement a state-managed continuum of services for mentally ill adults (who present symptoms of danger or grave passive neglect) and to provide inpatient assessment and care in a secure, locked facility. Ms. Gillette reviewed the planning process, the need for the project and the financial benefits of the project. She referred the committee to the project specifications, social rehabilitation model and qualification for services information contained in the handout.

Becky Beckett discussed some of the benefits of a step-up-step-down crisis residential facility for psychiatric patients who do not meet the criteria for inpatient admission or who are being discharged from an inpatient psychiatric setting.

Mr. Lynch suggested to the presenters that they work on the draft legislation with LCS because of the differences in recurring and non-recurring funds and the capital outlay process.

The meeting was adjourned at 5:36 p.m.